

Certification for Youth Camps 2018

**Maryland Department of Health
Environmental Health Bureau**

**Center for Healthy Homes and Community Services
6 Saint Paul St, Suite 1301
Baltimore, MD 21202-1608**

Phone 410-767-8417

Fax 410-333-8926



CHHCS Staff

Tommy McKenzie, Chief

410-767-8423

Tommy.McKenzie@maryland.gov

Linda Rudie, Section Head

410-767-8419

Linda.Rudie@maryland.gov

Brian Flynn, Section Head

410-767-8424

Brian.Flynn@maryland.gov

Nicole Alonge-Smart, Regional EHS

410-767-8422

Nicole.Alonge-Smart1@maryland.gov

Michael McNeely, Regional EHS

410-767-8426

Michael.McNeely@maryland.gov

Allegany ✦ Anne Arundel ✦ Calvert
Carroll ✦ Charles ✦ Frederick
Garrett ✦ Howard ✦ Montgomery
Prince George's ✦ St. Mary's
Washington

Baltimore City ✦ Baltimore ✦ Caroline
Cecil ✦ Dorchester ✦ Harford ✦ Kent
Queen Anne's ✦ Somerset ✦ Talbot
Wicomico ✦ Worcester

Mission Statement

MISSION

- The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION

- The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

Legal Authority/Regulation

- Law: Youth Camp Act:
Health General Title 14 Subtitle 4
- Regulation: COMAR 10.16.06
 - Updated in 2016
- Regulation: COMAR 10.16.07
 - Created in 2016
- Regulation: COMAR 10.01.17
 - Update in 2016

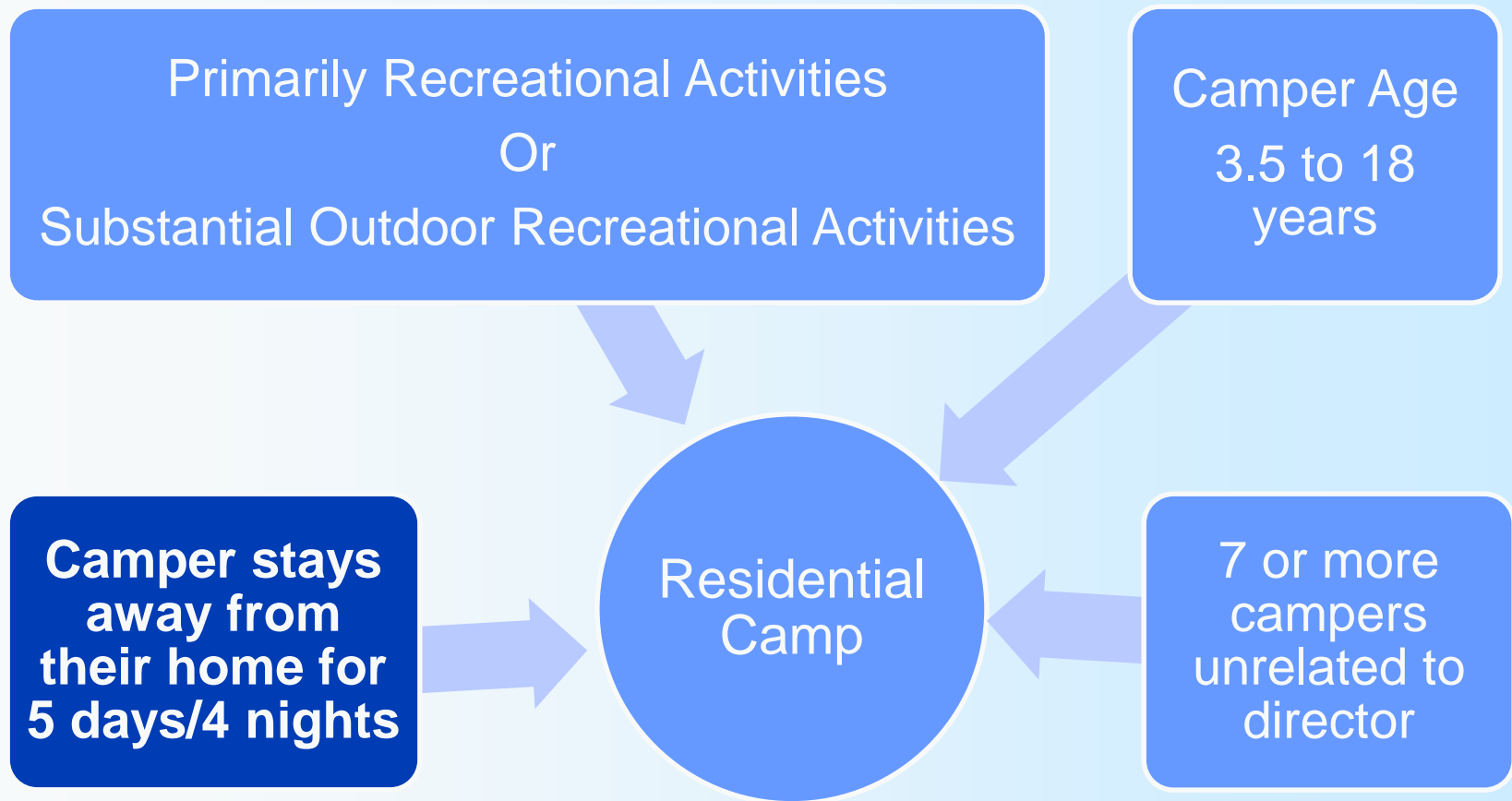


Is My Program a “Youth Camp”?





Is My Program a “Youth Camp”?



What Is **NOT** a Youth Camp?

- A licensed child care center
- A family day care home
- A program operating before or after a daily school session
- A competitive activity sponsored by a sports league
- An instructional program of 2 hrs. or less in a specialized activity

What Is **NOT** a Youth Camp?

- A summer school program taught by certified teacher and offering credit
- A program or activity where parents/guardians are present for duration, participate, and oversee activities of the child

What Is **NOT** a Youth Camp?

- A program enrolling children under the age of 3.5 years old cannot be licensed as a youth camp.
 - The operator should consult with Child Care Administration to see if a child care license is required.

New Application

- New Youth Camp Application
 - Print from Youth Camp website
<https://phpa.health.maryland.gov/OEHFP/CHS/Shared%20Documents/Youth%20Camps/ApplicationforNewYouthCamp.pdf>
Fill out completely, accurately, attach all required supporting documents, & fee
- Renewal Applications
 - Renewal packages are sent to operator
 - “Good Standing”- Pay reduced fee
- Applications not signed, submitted without fee, or with incorrect fee will not be reviewed and will be returned.



Fee Chart

Maryland Department of Health and Mental Hygiene
Center for Healthy Homes and Community Services
Youth Camp Application Fee Chart
Effective January 1, 2017

Day Camps		
Camper Days	Regular Fee	"Good Standing" Fee
1 to 500	\$190	\$45
501 to 2,000	\$500	\$125
2,001 to 5,000	\$665	\$165
5,001 or more	\$855	\$215

Residential, Day & Residential, Trip, or Travel Camps		
Camper Days	Regular Fee	"Good Standing" Fee
1 to 700	\$500	\$125
701 to 5,000	\$1,000	\$250
5,001 to 16,000	\$1,500	\$375
16,001 or more	\$2,000	\$500

Renewal Application

- Renewal Applications
 - Renewal packages are sent to operator
 - “Good Standing”- Pay reduced fee
 - Application submitted on time
 - Annual Report submitted on time
 - All fees paid
 - No Critical Violations for 2 years
 - Self-Assessment submitted on time
- Applications not signed, submitted without fee, or with incorrect fee will not be reviewed and will be returned.

Criminal Background Checks

COMAR 10.16.06.21

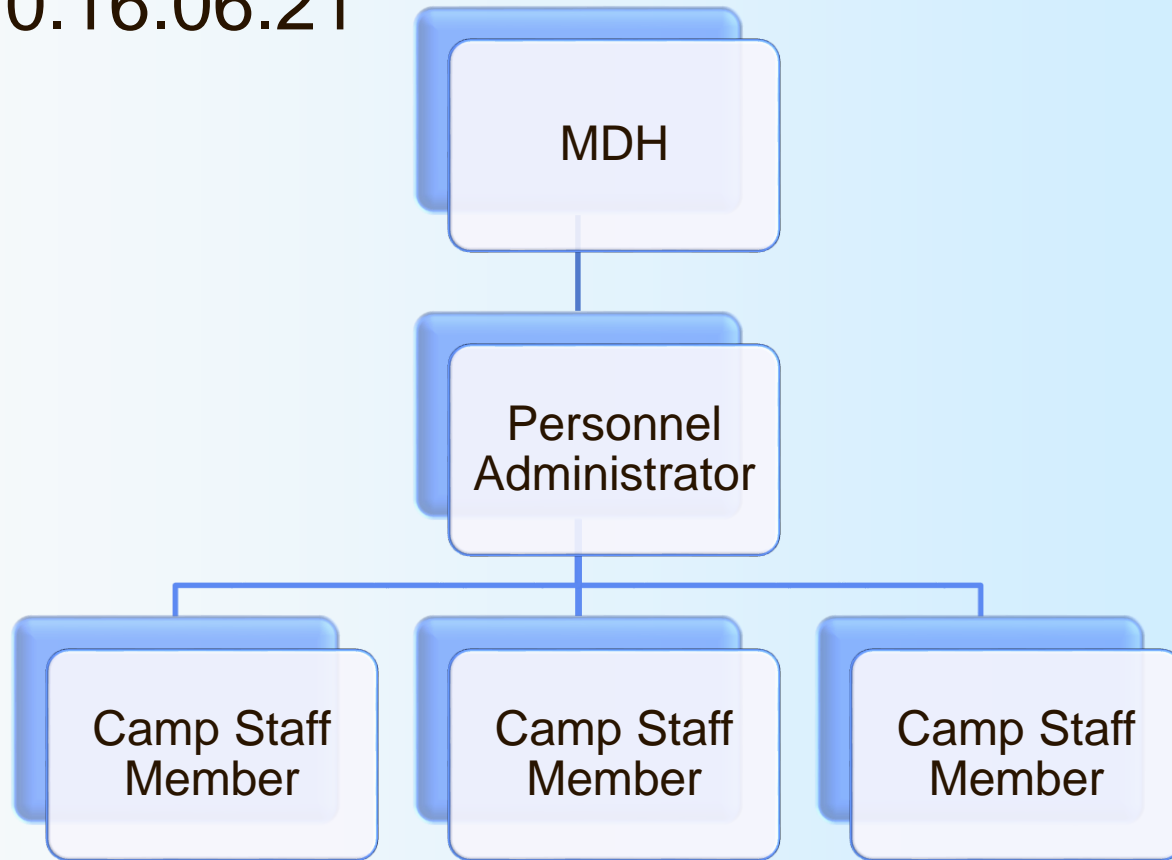


© Viviane Moos



Criminal Background Checks

COMAR 10.16.06.21





Authorization Number

For CJIS use Only
Authorization #:

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES (ITCD)
CRIMINAL JUSTICE INFORMATION SYSTEM (CJIS) - CENTRAL REPOSITORY (CR)
GENERAL REGISTRATION FORM

I. COMPANY OR AGENCY NAME: _____
CONTACT PERSON: _____
(This is the person to whom all correspondence will be addressed)
CONTACT PERSON'S POSITION TITLE: _____
CONTACT PERSON'S TELEPHONE NUMBER: _____ EXT: _____
MAILING ADDRESS: _____
FAX NUMBER: _____ E-MAIL ADDRESS: _____

II. REASON FOR REQUEST:

☐ ADULT DEPENDENT CARE (For Maryland Adult Dependent Program ONLY)
☐ ATTORNEY/CLIENT
☒ CHILD CARE (For Maryland Child Care Facilities ONLY)
☐ CRIMINAL JUSTICE (For Criminal Justice Agencies ONLY)
☐ GOVERNMENT EMPLOYMENT (select one only) ☐ Federal ☐ State ☐ Local
☐ GOVERNMENT LICENSING/CERTIFICATION
☐ PUBLIC HOUSING AUTHORITY

IF AUTHORIZED BY STATUTE, ENTER STATUTORY CITATION: _____

III. CERTIFY THAT UNDER THE SPIRIT AND INTENT OF THE LAWS OF MARYLAND, I
UNDERSTAND THAT DATA RETURNED TO ME CAN ONLY BE USED AS REQUESTED AND
THAT I AM NOT AUTHORIZED FOR FURTHER DISSEMINATION.

Signature _____ Date _____ Title _____

MAIL SIGNED AND COMPLETED FORM TO: CJIS AUTHORIZATION ADMINISTRATOR
POST OFFICE BOX 32708
PIKESVILLE, MARYLAND 21282-2708
410 653 5690

OR FAX SIGNED AND COMPLETED FORM TO: 410 653 5690

Revised 3/4/03

- Camp applies for Authorization Number through **CJIS**
- Results are sent to contact person
- Email notification
- View/print results from secure web site



Criminal Background Checks

Maryland


And


FBI

- Must have completed MD & FBI check for all required employees
- Copy of results must be addressed to employer, not the employee

Criminal Background Checks

State of Maryland
Department of Public Safety and Correctional Services


Martin O'Malley
Governor



G. Lawrence Franklin
Deputy Secretary
Ronald C. Brothers
Chief Info. Officer
C. Kevin Combs
Deputy Chief Info. Officer
Carole Shelton
Director

Information Technology and Communications Division
Criminal Justice Information System - Central Repository
Post Office Box 32708 - Pikesville, Maryland - 21282-2708
Main No: 410-764-4501 - Toll Free: 1-888-795-0011
www.dpscs.state.md.us

Anthony G. Brown
Lt. Governor
Gary D. Maynard
Secretary

MARYLAND DEPARTMENT OF HEALTH & MENTAL HYGIENE/ OFPCHS
LINDA RUDIE
6 ST. PAUL STREET, SUITE 1301, DIVISION OF COMMUNITY SERVICES
BALTIMORE, MD 212021608

Received: 02/02/2011
Reference: 1 [REDACTED]

February 02, 2011

Your request for a criminal history record check of Maryland's Criminal Justice Information System has been completed. This record check was based upon the identification information provided as follows:

NAME: [REDACTED]
Sex: [REDACTED] Race: [REDACTED] Date of Birth: [REDACTED]

No criminal history was found under the Maryland statute or regulation authorizing you to receive the information.

A fingerprint supported national criminal history record check has been initiated. The results of that investigation will be sent to the requesting agency only.


The Maryland Criminal Justice Information System is operated under the authority of the Secretary of the Department of Public Safety and Correctional Services and may not contain data prior to 1978.


Carole Shelton

Carole Shelton, Director
Criminal Justice Information Systems
Central Repository

February 02, 2011 - 1 [REDACTED] - R_CJIS Fac410-653-6320

State of Maryland
Department of Public Safety and Correctional Services


Martin O'Malley
Governor



G. Lawrence Franklin
Deputy Secretary
Ronald C. Brothers
Chief Info. Officer
C. Kevin Combs
Deputy Chief Info. Officer
Carole Shelton
Director

Information Technology and Communications Division
Criminal Justice Information System - Central Repository
Post Office Box 32708 - Pikesville, Maryland - 21282-2708
Main No: 410-764-4501 - Toll Free: 1-888-795-0011
www.dpscs.state.md.us

Anthony G. Brown
Lt. Governor
Gary D. Maynard
Secretary

MARYLAND DEPARTMENT OF HEALTH & MENTAL HYGIENE/ OFPCHS
LINDA RUDIE
6 ST. PAUL STREET, SUITE 1301, DIVISION OF COMMUNITY SERVICES
BALTIMORE, MD 212021608

Received: 02/02/2011
Reference: 1 [REDACTED]

Originally printed: 2011-02-02

February 02, 2011

Your request for a criminal history record check has been conducted. Information from the Federal Bureau of Investigation (FBI) based upon the fingerprint supported identification information indicated below, has been reviewed.

Name: [REDACTED]
Sex: [REDACTED] Race: [REDACTED] Date of Birth: [REDACTED]

The FBI criminal history investigation has been completed. The covered individual is not the subject of any criminal charge/charges.

The Maryland Criminal Justice Information System is operated under the authority of the Secretary of the Department of Public Safety and Correctional Services and does not contain data prior to 1978.


Carole Shelton

Carole Shelton, Director
Criminal Justice Information Systems
Central Repository

February 02, 2011 - 1 [REDACTED] - R_FBI Fac410-653-6320



Fingerprints


STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION APPLICATION

APPLICANT INFORMATION (PLEASE TYPE OR PRINT CLEARLY)

Name: _____

Date of birth: _____ SSN: _____ Gender: ☐ Male ☐ Female (Please check)

Height: ft. _____ inches _____ Weight: _____ lbs. _____ Eye Color: _____ Hair Color: _____

Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American ☐ Other (Please check)

Place of Birth: _____ Citizenship: _____

Current address: _____

City: _____ State: _____ ZIP Code: _____

Daytime Phone: _____ Evening Phone: _____ Driver's License #: _____

AGENCY INFORMATION

Agency Authorization #: _____

ORI # (if required): MD004455Y Reason fingerprinted? CHILD CARE

Position Applied for: _____

Request Type: (Choose one ONLY)

<input type="checkbox"/> Adult Dependent Care	<input type="checkbox"/> Government Licensing or Certification
<input type="checkbox"/> Attorney/Client	<input type="checkbox"/> Immigration/VISA
<input checked="" type="checkbox"/> Child care	<input type="checkbox"/> Individual Challenge
<input type="checkbox"/> Criminal Justice	<input type="checkbox"/> Individual Review
<input type="checkbox"/> Gold Seal/ Adoption	<input type="checkbox"/> MSP Licensing
<input type="checkbox"/> Gold Seal/Letter/VISA	<input type="checkbox"/> Private Party Petition
<input type="checkbox"/> Government Employment	<input type="checkbox"/> Public Housing

Mail Response to:
(Mailing option only available for Visa Gold Seal and/or Individual Review)

APPLICANT

NAME: _____

DATE OF BIRTH: _____

SSN: _____

PLACE OF BIRTH: _____

CITIZENSHIP: _____

CURRENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DAYTIME PHONE: _____ EVENING PHONE: _____ DRIVER'S LICENSE #: _____

AGENCY INFORMATION

AGENCY AUTHORIZATION #: _____

ORI # (if required): MD004455Y Reason fingerprinted? CHILD CARE

POSITION APPLIED FOR: _____

REQUEST TYPE: (Choose one ONLY)

<input type="checkbox"/> Adult Dependent Care	<input type="checkbox"/> Government Licensing or Certification
<input type="checkbox"/> Attorney/Client	<input type="checkbox"/> Immigration/VISA
<input type="checkbox"/> Child care	<input type="checkbox"/> Individual Challenge
<input type="checkbox"/> Criminal Justice	<input type="checkbox"/> Individual Review
<input type="checkbox"/> Gold Seal/ Adoption	<input type="checkbox"/> MSP Licensing
<input type="checkbox"/> Gold Seal/Letter/VISA	<input type="checkbox"/> Private Party Petition
<input type="checkbox"/> Government Employment	<input type="checkbox"/> Public Housing


Mail Response to:
(Mailing option only available for Visa Gold Seal and/or Individual Review)

**Maryland CJIS no longer accepts inked fingerprints
as of April 15, 2012, except for out of state.
Use LIVESCAN PRE-REGISTRATION APPLICATION**

Personnel Administrator

- MDH must have the personnel administrator's criminal background results from CJIS
- Use MDH Authorization Number: 9400019171
- ***DO NOT USE THIS AUTHORIZATION NUMBER FOR OTHER STAFF MEMBERS***

365 Day Request


 STATE OF MARYLAND
 DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
 CENTRAL REPOSITORY
 P.O. BOX 32706
 Pikesville, MD 21202-2706

365 DAY REQUEST FOR CHILD CARE CRIMINAL HISTORY RECORD CHECK

NAME _____
 (Last) (First) (MI)

ADDRESS _____
 (Number) (Street) (P.O. Box)

 (City) (State) (Zip Code)

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH ____/____/____
(This information is required under Article 27, § 742.255, Maryland Annotated Code and under COMAR 12.15.01 in order verify and preserve security of the record)

THE REFERENCE NUMBER FROM YOUR MOST RECENT CHILD CARE APPLICATION FOR A FINGERPRINT SUPPORTED CRIMINAL HISTORY RECORD CHECK (the check must have occurred within the past 365 days).

 (12 DIGIT NUMBER)

I hereby give my consent for requested Child Care Criminal History Information to be forwarded to the employer listed below.

SIGNATURE OF EMPLOYEE _____ DATE _____

TO BE COMPLETED BY NEW EMPLOYER: Please list complete mailing address.

 (EMPLOYER NAME)

 (ADDRESS)

 (CITY) (STATE) (ZIP CODE)

AUTHORIZATION NUMBER: _____

AUTHORIZED SIGNATURE: _____

DATE: _____

MAIL TO: CJIS CENTRAL REPOSITORY, P.O. BOX 32706, PIKESVILLE, MD. 21202-2706
 Customer Assistant Desk: (410) 744-4501 Fax: (410) 455-5690 Alt. Fax: (410) 455-4320

FOR CJIS CENTRAL REPOSITORY USE ONLY

This request can not be processed because:

_____. This is not a valid reference number

_____. This is not a valid authorization number

_____. This reference number has not been received at the Central Repository

_____. This authorization number is not approved for this request.

_____. The application associated with this reference number was received more than 365 days before receipt of this request.

_____. Requested information is not completed

- Use for individuals who were fingerprinted for child care within last year
- Does not require fingerprints
- No charge

Background Clearance from Child Protective Services

- All employees must complete CPS Release of Information Form (DHR/SSA 1279).
- Personnel Administrator should use the sample form provided which includes the contact information for MDH-CHHCS.

Reviewing Background Checks and Clearances

- Personnel Administrator must review MD and FBI background checks and CPS background clearance information.
- No hits for something in Regulation .21E.
- If hit for something in Regulation .21F must review accordingly.

Procedures

Emergency Procedures

- Regulation 10.16.06.34

Trip and Transportation

- Regulations 10.16.06.52, and .53

Supervision during routine activities

- Regulation 10.16.06.54

Specialized Activities

- Regulations 10.16.06.47, through .52

Child Abuse Prevention and Reporting

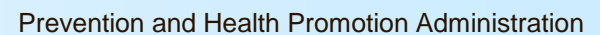
- Regulation 10.16.06.35

Emergency Procedures

- Regulation 10.16.06.34
 - Natural disasters and severe weather



–Evacuation plan



Emergency Procedures

–Missing campers



1

2

3

5

4

6 ?



Emergency Procedures

–911





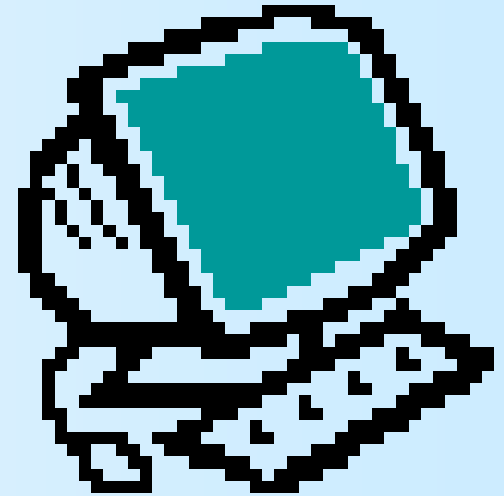
Emergency Procedures

–Transportation for Evacuation



Emergency Procedures

–Notify parents



Emergency Procedures

–Ensure camper safety



Trip and Transportation

- Regulations 10.16.06.52 and .53
- Written Safety Plans for:
 - Field trips (See Handout)
 - Transportation (See Handout)
 - Safety Seats for Younger Children
- Written parental authorization
- Rules
- Supervision

Specialized Activities Regulation .47 - .52

- All Specialized Activities
 - Director Present
 - Safety Plan Developed and Implemented
 - Staff Training
 - Staff Ratio (1 staff to 10 campers)
- Swimming
 - Swim ability test
 - Safety system to quickly account for campers
 - WATCHERS, WATCHERS, WATCHERS
- Marksmanship
- Horseback Riding

Specialized Activities

Change to Regulation .51

A helmet is required for rock climbing or high ropes activities, except when an auto-belay system is utilized.

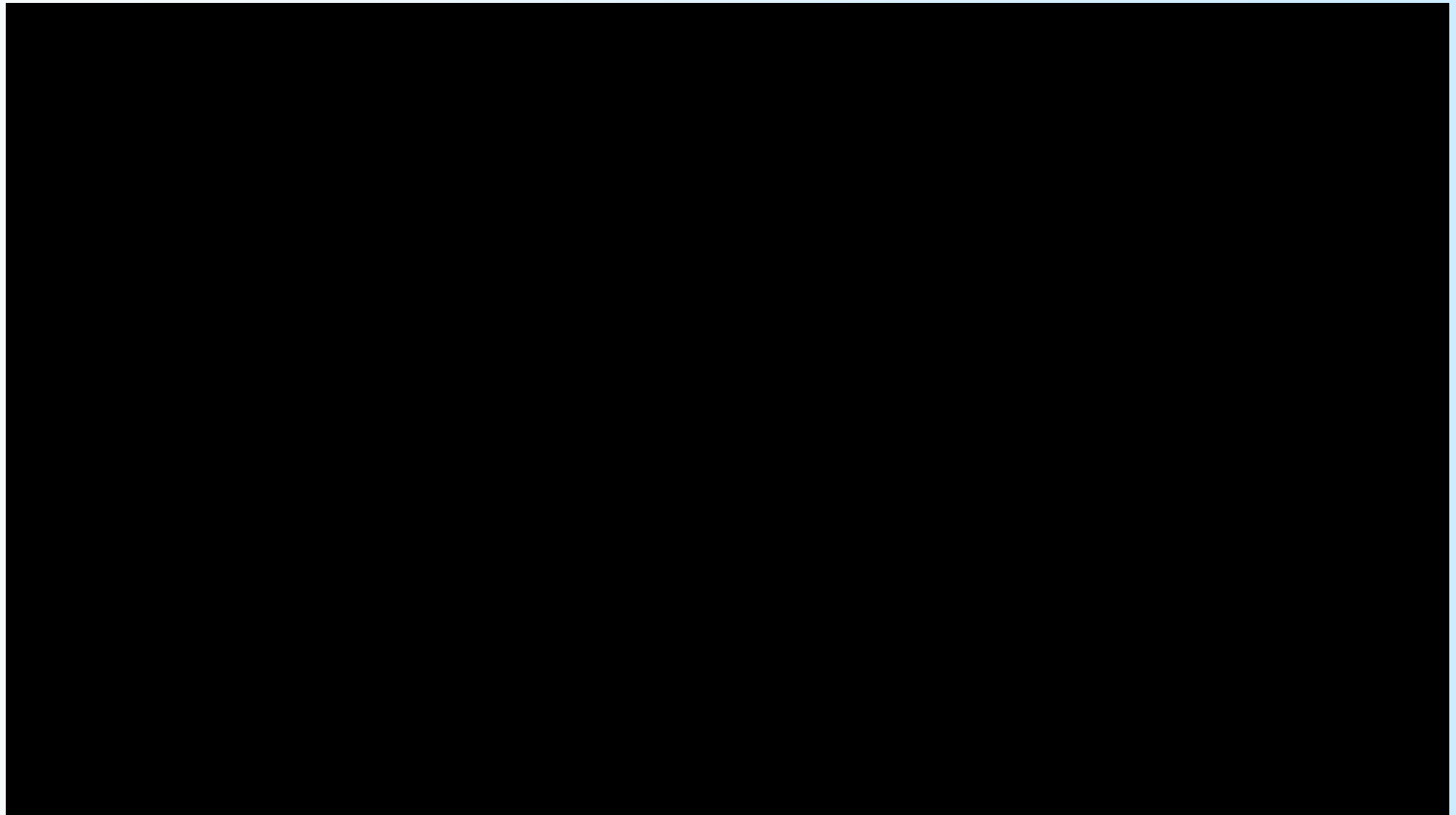




Supervision

Campers	Required Number of Adults and Assistant Counselors	
	Adults	Assistant Counselors or Adults
3 ½ to 5 years old		
1 to 8	1	0
9 to 16	1	1
17 to 24	1	2
6 to 10 years old		
1 to 15	1	0
16 to 30	1	2
	Or 2	0
11 years old or older		
1 to 15	1	0
16 to 30	1	2
	Or 2	0
31 to 40	2	2
	Or 3	0

Child Abuse Prevention and Reporting Mandated Reporters



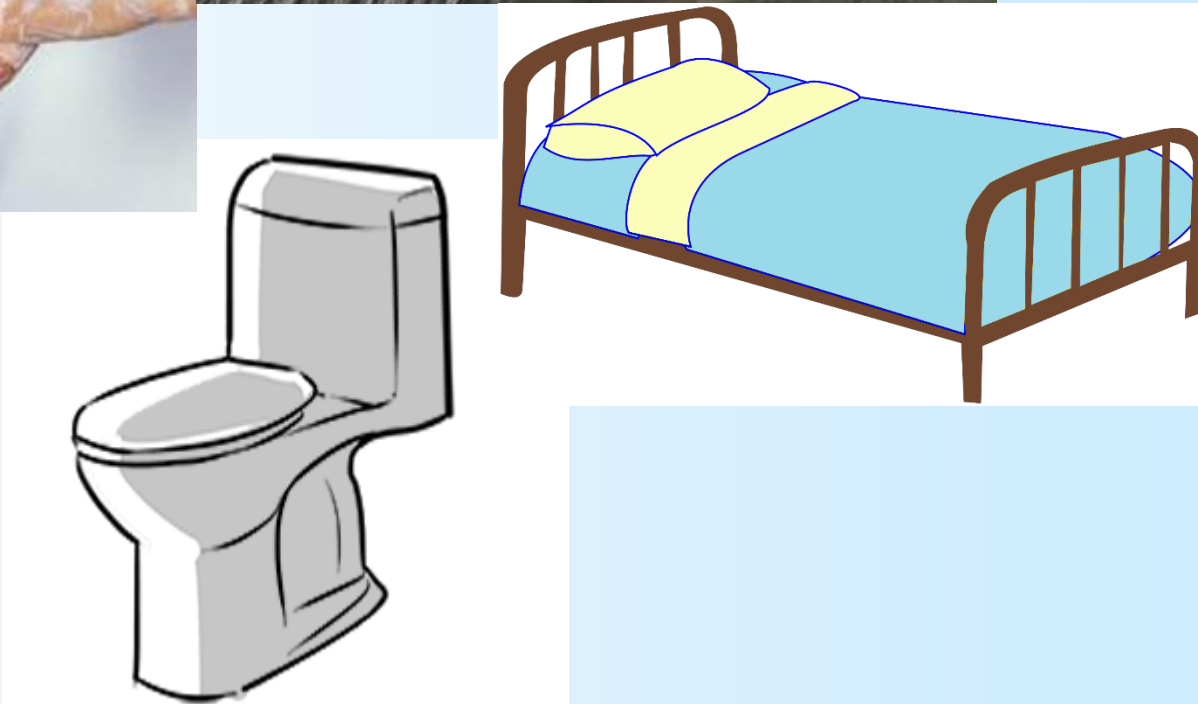
Child Abuse Prevention and Reporting

Regulation 10.16.06.35

- Develop and implement child abuse prevention and reporting plan ***see handout***
- Provide training to staff members on the prevention and reporting plan annually
- Keep sign-in sheet for training on file
- Keep a copy of the local DSS numbers on file



MARYLAND
Department of Health



Facilities

Type of Facility	Day	Residential
1 Toilet per	35 campers	15 campers
1 Hand Washing Unit per	35 campers	25 campers
1 Showerhead per	N/A	15 campers
1 Bed, Cot or Bunk per	N/A	1 camper

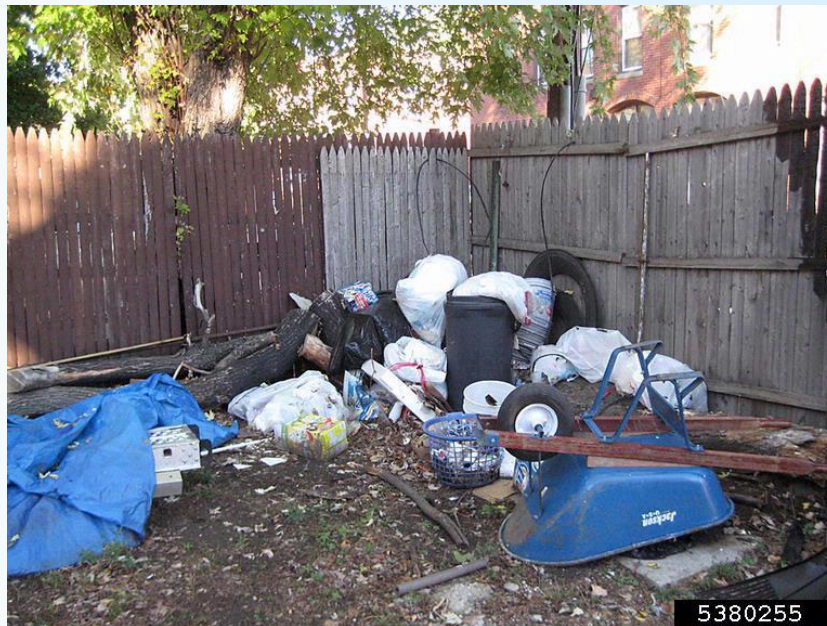
Facilities

- Garbage removal, COMAR 10.16.06.43
 - Durable containers in good repair
 - Collected as necessary to prevent overflow
 - Disposed of legally
 - Outside containers have:
 - Tight-fitting Lids
 - Are leak-proof, fly-proof, and rodent-proof



Facilities

- Insect and rodent control, COMAR 10.16.06.44
 - Minimize entry
 - Eliminate harborage



Documentation for Private Building

- Building
 - Use and Occupancy Permit
 - Or
 - Master Plumber and Master Electrician Letters
- Water and Sewage
 - Public Water and Sewer
 - Or
 - Local Health Approval Form
- Fire Marshal Inspection
- Food Service Facility Permit from LHD
- Swimming Pool Permit from LHD

Documentation for School/Government Building

- Building Safety Form
 - Covers:
 - Water
 - Sewage Disposal
 - Plumbing
 - Electrical
 - Fire
 - Building/Zoning
- Food Service Facility Permit from LHD
- Swimming Pool Permit from LHD



Health Program

Health Supervisor

COMAR 10.16.07.04

- Doctor
- Nurse
- Certified Nurse Practitioner
- **Duties**
 - Review & Approve Health Program Annually
 - Oversee or Delegate Medication Administration
 - Oversee Health Treatment Area
 - Review Camper Health Forms

Health Program

CPR/First Aid

COMAR 10.16.07.04

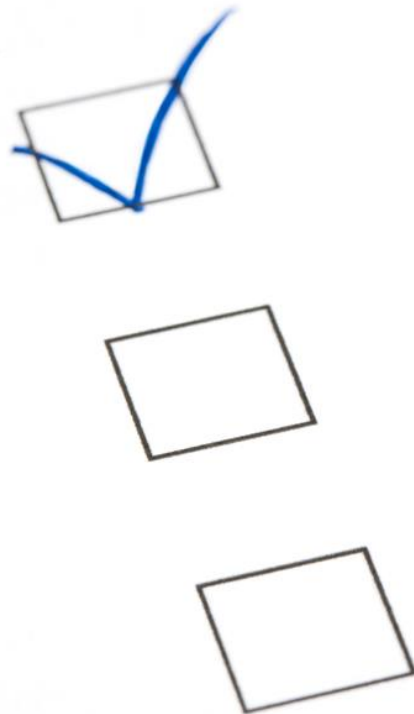
- Minimum of 2 Adults
 - Certification Issued by National Organization
- On Duty at All Times
 - From 1st camper arrival to last camper pick up
- Field Trips
 - One with trip and one at camp if campers stay behind



Health Program

Written Health Program

COMAR 10.16.07.03



Refer to list of questions
provided in your packet.

Health Program

Medications

COMAR 10.16.07.14

- Covers Prescription and Nonprescription Medications
- Delegation ability varies depending on credentials of Health Supervisor
- Self-administration vs. Staff Administration
- Prescriptive Order for All Medication – MDH form
(may be used at multiple camps for one season)
- Parental Consent Documented
- Standing Orders
- Sunscreen, see January 25, 2017 memo

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- Applicant = Someone that:
 - 1) Operates a youth camp
 - 2) Is at least 18 years old
 - 3) Has successfully completed an emergency epinephrine training program approved by the department.

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- The applicant may apply to the Department for a Certificate for Emergency Epinephrine by submitting a written policy that includes:

- 1) Designation of agents
- 2) The name of the approved emergency epinephrine educational training program
- 3) Procedures to:
 - a) Store the epi pen
 - b) Notify parents it is available
 - c) Maintain epi pen in secure manner
 - d) Report use of epi pen according to .06
 - e) Train certificate holder and agent annually
 - f) Keep training docs. for 3 years

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

•An emergency epinephrine educational training program shall include:

- 1) The signs and symptoms of anaphylaxis
- 2) Use of an emergency auto-injectable epinephrine pen
- 3) Follow-up procedures with a parent or guardian after an emergency auto-injectable epinephrine is administered
- 4) A skills demonstration
- 5) A written examination

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- An individual teaching an emergency epinephrine educational training program shall be licensed as a physician, a register nurse, or a certified nurse practitioner.

Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- A certificate for emergency epinephrine holder may:
 - 1) On presentment of a certificate for emergency epinephrine, receive from any physician licensed to practice medicine in the State a prescription for auto-injectable epinephrine; and
 - 2) Possess and store prescribed auto-injectable epinephrine



Health Program

(Optional) Emergency Epinephrine

COMAR 10.16.07.15

- In an emergency, a certificate for emergency epinephrine holder or agent may administer auto-injectable epinephrine to an individual who is experiencing or believed in good faith by the certificate holder or agent to be experiencing anaphylaxis.



Health Program

Treatment Area

COMAR 10.16.07.13

Day
Camp





Health Program

Treatment Area

COMAR 10.16.07.13

Residential Camp

Hot/Cold
Running
Water

Bathroom
with Flush
Toilets

Hand Sink,
Shower, and
Isolation &
Convalescent
Area

External
Lighting

Health Program

Health Records

COMAR 10.16.07.08

CAMPER HEALTH HISTORY

Child's Name: _____

The following information is required:

Parent or Legal Guardian: _____ Phone: _____

Emergency Contact Person: _____ Phone: _____

Child's Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ YES ☐ NO

☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive? ☐ YES ☐ NO

☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

For campers who reside within the United States, a United States territory, or the District of Columbia:

1. State/territory in which child resides: _____

2. Is this child exempt from any immunizations? ☐ YES ☐ NO

☐ YES, List them: _____

OR

↔

For campers who reside outside the United States, a United States territory, or the District of Columbia:

1. Country in which child resides: _____

2. Attach Department form DHMH-896 (record of vaccination or immunity)

Parent or Legal Guardian's Signature: _____ Date: _____

Health Program

Health Records

COMAR 10.16.07.09

STAFF/VOLUNTEER HEALTH HISTORY

Staff Member's/Volunteer's Name: _____

The following information is required:

Emergency Contact Person: _____ Phone: _____

Primary Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ YES ☐ NO

☐ YES, Explain: _____

2. Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware? ☐ YES ☐ NO

☐ YES, Explain: _____

IMMUNIZATION INFORMATION:

<p>For staff members/volunteers who reside within the United States, a United States territory, or the District of Columbia:</p> <p>1. State/territory in which person resides: _____</p> <p>2. Is this person exempt from any immunizations? <input type="checkbox"/> YES, List them: _____ <input type="checkbox"/> NO</p> <p>_____</p> <p>_____</p>	<p>OR</p> <p>↔</p>	<p>For staff members/volunteers who reside outside the United States, a United States territory, or the District of Columbia:</p> <p>1. Country in which person resides: _____</p> <p>2. Attach Department form DHMH-896 (record of vaccination or immunity)</p>
--	--------------------	--

Staff Member/Volunteer Signature or _____ Date _____

Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years)



Health Program

Health Log

COMAR 10.16.07.05



See Sample Health Log

Must Be:

1. On Lined Paper
2. Kept Confidential
3. In Locked Compartment
4. Available to Department
5. Retained for 3 years
6. Recorded in Ink
7. No Skipped Lines
8. Spiral Book Must Have Sequentially Numbered Pages



Must Include:

1. Date
2. Name of Camper
3. Ailment
4. Treatment Prescribed
5. Name or Initials of Person Administering Care





Health Program

Incident Report

COMAR 10.16.07.06 and .07

MARYLAND YOUTH CAMP INCIDENT REPORT FORM

Department of Health and Mental Hygiene (DHMH)
Center for Healthy Homes and Community Services (CHHCS)
601 Paul Street, Suite 1301, Baltimore MD 21202-1009
Phone 410-767-8417 Toll Free 1-877-4MD-DHMH ext.8417 Fax 410-333-8926

A. PERSONAL INFORMATION		4. Check One <input type="checkbox"/> Day Camper <input type="checkbox"/> Residential Camper <input type="checkbox"/> Camp Employee <input type="checkbox"/> Other:	
1. Name (DO NOT INCLUDE NAME ON COPY SENT TO DHMH)	2. Age	3. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
B. INCIDENT INFORMATION. Complete items 5 through 14 for an injury, illness, medication error, or epinephrine.			
5. Report Type (check one) <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Medication Error <input type="checkbox"/> Epinephrine		6. Date of Incident/Illness Onset	7. Time of Incident/Illness Onset AM PM
8. Provide short description, do not include names: <input type="checkbox"/> Additional information attached			
9. Did the incident require any of the following: AED: <input type="checkbox"/> No <input type="checkbox"/> Yes CPR: <input type="checkbox"/> No <input type="checkbox"/> Yes Epinephrine: <input type="checkbox"/> No <input type="checkbox"/> Yes Inhaler: <input type="checkbox"/> No <input type="checkbox"/> Yes			
10. Was the person transported off-site for medical care? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete A. and B. A. Transported by: <input type="checkbox"/> Camp vehicle <input type="checkbox"/> Personal vehicle <input type="checkbox"/> Ambulance <input type="checkbox"/> Helicopter B. Treated or evaluated at (check all that apply, specify the name of facility): <input type="checkbox"/> Urgent Care <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other		11. After off-site or on-site medical evaluation, the person (check all that apply): <input type="checkbox"/> Was admitted to the hospital <input type="checkbox"/> Went home. Date: _____ <input type="checkbox"/> Returned to camp with medical restrictions <input type="checkbox"/> Returned to camp with no restrictions 12. Did incident result in death? <input type="checkbox"/> No <input type="checkbox"/> Yes List Date of death: / / List Time of death: am/pm	
13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury? <input type="checkbox"/> No <input type="checkbox"/> Yes 14. Did the incident prompt a report or investigation by government authorities or officials? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): Government Agency: _____ Report/Investigation Date: _____ Report/Investigation Number: _____		15. Specify the body part(s) injured: 16. What caused the injury (check one, specify below): <input type="checkbox"/> Site <input type="checkbox"/> Burn <input type="checkbox"/> Contact/obstruction with <input type="checkbox"/> Person or <input type="checkbox"/> Object <input type="checkbox"/> Drowning <input type="checkbox"/> Near-Drowning <input type="checkbox"/> Fall <input type="checkbox"/> Trip/Slip <input type="checkbox"/> Hazardous Material Exposure <input type="checkbox"/> Poisoning <input type="checkbox"/> Weapon <input type="checkbox"/> Other (specify): specify by what: _____ 17. Was the injury: <input type="checkbox"/> Unintentional (accidental) <input type="checkbox"/> Intentional (self-inflicted) <input type="checkbox"/> Intentional (inflicted by another) 18. Did the individual sustain a (check all that apply): <input type="checkbox"/> Concussion <input type="checkbox"/> Other Head Injury <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Severe Laceration <input type="checkbox"/> Fracture <input type="checkbox"/> None of above	
19. Describe where the injury occurred: <input type="checkbox"/> On Site <input type="checkbox"/> Off Site Specify location: _____ 20. Specify the activity the individual was engaged in at the time of injury (select most applicable activity): <input type="checkbox"/> Archery <input type="checkbox"/> Arts & Crafts <input type="checkbox"/> Biking <input type="checkbox"/> Boating (specify): _____ <input type="checkbox"/> Competitive Sports/Games (specify): _____ 21. Was the activity supervised? <input type="checkbox"/> Not Applicable <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) # of campers in activity: _____ # of staff in activity: _____ 22. Was the individual using safety equipment? <input type="checkbox"/> No <input type="checkbox"/> Not Applicable <input type="checkbox"/> Yes (specify): _____		23. Continued: <input type="checkbox"/> Motorized Vehicle (specify): _____ <input type="checkbox"/> Playground <input type="checkbox"/> Primitive Camping <input type="checkbox"/> Riffing <input type="checkbox"/> Rock Climbing/Rappelling <input type="checkbox"/> ropes Course/Challenge Course/Zip-line <input type="checkbox"/> Swimming <input type="checkbox"/> Walking/Running/Hiking <input type="checkbox"/> Other (specify): _____	
D. ILLNESS 23. DHMH requires certain diseases, conditions, outbreaks and unusual manifestations reported to the local health department. A. Was the illness a suspected reportable disease, condition or outbreak? <input type="checkbox"/> No <input type="checkbox"/> Yes For the required DHMH reportable diseases list and outbreak information go to: http://www.dhmdhs.state.md.us/CHH/CHHData/Documents/what-to-report/ReportableDisease_HCP.pdf B. Was the illness reported to a local health department? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify department): _____ The camp health supervisor or responding health care provider completes Provider Report Form # 1140 when reporting to the local agency - go to: http://www.dhmdhs.state.md.us/CHH/CHHData/Documents/what-to-report/ProviderReportForm1140.pdf			
E. MEDICATION ERROR 24. Right Patient? <input type="checkbox"/> No <input type="checkbox"/> Yes, Right Patient? <input type="checkbox"/> No <input type="checkbox"/> Yes, Right Time? <input type="checkbox"/> No <input type="checkbox"/> Yes, Right Dose? <input type="checkbox"/> No <input type="checkbox"/> Yes, Right Route? <input type="checkbox"/> No <input type="checkbox"/> Yes 25. Type of administration: <input type="checkbox"/> Self-Administration: Was camp staff supervising the self-administration? <input type="checkbox"/> No <input type="checkbox"/> Yes Was medication secured? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Staff administration: Staff person's training level (check one): <input type="checkbox"/> Office of child care (6 hour course) <input type="checkbox"/> Certified Medication Technician <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> CNP			
F. EPINEPHRINE 25. Who administered the epinephrine? Name and Title: _____ 27. Was the epinephrine prescribed to: the individual? <input type="checkbox"/> or the Camp, Epinephrine Certificate Holder? <input type="checkbox"/> No <input type="checkbox"/> Yes 28. Triggers: <input type="checkbox"/> Unknown or <input type="checkbox"/> Known (specify): _____ 29. Symptoms (check all that apply): <input type="checkbox"/> Skin reaction, <input type="checkbox"/> Feeling of warmth, <input type="checkbox"/> Sensation of a lump in the throat, <input type="checkbox"/> Constriction of the sinuses, swollen tongue, trouble breathing, <input type="checkbox"/> Rapid pulse, <input type="checkbox"/> Nausea, vomiting or diarrhea, <input type="checkbox"/> Dizziness or lightheadedness			
30. Report Completed By: Employee Name (print) _____ Title _____ 31. Camp Name _____ Address _____ DHMH CAMP ID # _____ Parent, Guardian, or Emergency Contact was notified <input type="checkbox"/> No <input type="checkbox"/> Yes Date _____ Method _____ 32. Camp Health Supervisor was notified <input type="checkbox"/> No <input type="checkbox"/> Yes Health Supervisor Name _____ Date _____ Method _____ 33. DHMH/CHS was notified within 24 hours <input type="checkbox"/> No <input type="checkbox"/> Yes DHMH Contact Name _____ Date _____ Method _____ Employee Signature _____ Date _____ Phone Number _____			

DHMH-4762 01/2017

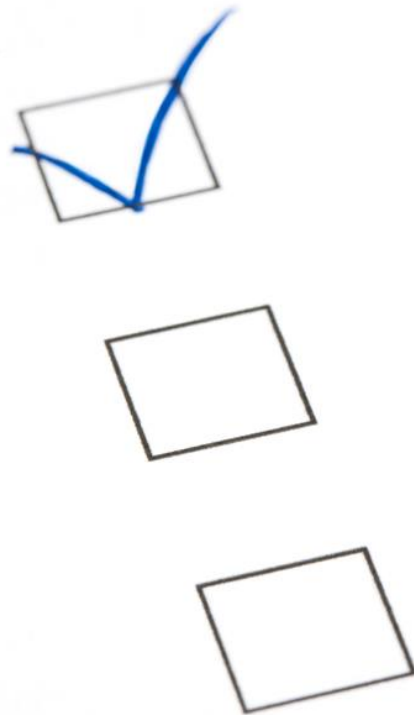
Maintain this report for at least 3 years.



Health Program

Acute Illness & Communicable Disease

COMAR 10.16.07.12



Refer to list provided in
your packet.

Staff Training and Certification

- Training
 - Document staff training for the following:
 - Health Program
 - Including Medication Administration
 - Emergency Plan
 - Trip Safety Plan
 - Transportation Safety Plan
 - Specialized Activities Safety Plans
 - Child Abuse Prevention and Reporting
- CPR and First Aid certification
 - Document current CPR/first aid
 - Ensure that at least 2 adults with CPR/FA are on duty during camp

Submitting Required Reports

- COMAR 10.16.06.06 and COMAR 10.16.07.06
- Annual Report must be sent to Center for Healthy Homes and Community Services within 4 weeks of camp ending along with any required injury/illness reports.

Submitting Required Reports

- Camps will be able to submit Annual Report online.

<https://envhlthlicensing.health.maryland.gov/Account/Login>

- MDH is working on finalizing the Incident Report for online submission as well.



Questions

